

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10672

10672

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 OAKLAND MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle JANE Last ASH.				4. DATE OF DEATH Month OCT. Day 23 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL-3-1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 2 Days 3		IF UNDER 24 HRS. Hours 4 Min. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY SPRINGS PA.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME JOHN BENDER				14. MOTHER'S MAIDEN NAME HOLDA GLASS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ROBERT ASH		Address OAKLAND MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 yrs 4-5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke 3 mos ago						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-23-1957 , to 10-20-1957 , that I last saw the deceased alive on 10-20-1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D. 58 2nd St. OAKLAND MD				DATE SIGNED 10-24-57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-27-1957		22c. NAME OF CEMETERY OR CREMATORY GLADES CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR BITTINGER MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24. REC'D BY REGISTRAR 10/27/57	
				24b. REGISTRAR'S SIGNATURE [Signature]			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10673

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON <input checked="" type="checkbox"/> d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEVI Middle MARTIN Last BITTINGER		4. DATE OF DEATH Month OCT Day 27 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODS		10b. KIND OF BUSINESS OR INDUSTRY CUTTING POSTS	
11. BIRTHPLACE (State or foreign country) GARRETT Co, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVI BITTINGER		14. MOTHER'S MAIDEN NAME REBECCA BITTINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-18-4813	
17. INFORMANT Robert Bittinger, Swanton RD #2 MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Scientific Heart Disease (c) 440.0 DUE TO (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Immed. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X And "210" for past week		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Feaster Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> acting	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-30-57	
22c. NAME OF CEMETERY OR CREMATORY LAUREL HILLS		22d. LOCATION (City, town, or county) MASCON, ALLEGANY (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DONALD J. THURMAN - Grantsville MD		24a. REC'D BY REGISTRAR NOV 1 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Julia Rowan	

RECEIVED

NOV 1 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF DEATH: _____

5. TIME OF DEATH: _____

6. PLACE OF DEATH: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF EXAMINER: _____

10. SIGNATURE OF WITNESS: _____

11. SIGNATURE OF CORONER: _____

12. SIGNATURE OF JURY: _____

13. SIGNATURE OF JUDGE: _____

14. SIGNATURE OF CLERK: _____

15. SIGNATURE OF SHERIFF: _____

16. SIGNATURE OF DEPUTY SHERIFF: _____

17. SIGNATURE OF CONSTABLE: _____

18. SIGNATURE OF TOWNSHIP CLERK: _____

19. SIGNATURE OF VOTING CLERK: _____

20. SIGNATURE OF TOWN CLERK: _____

21. SIGNATURE OF TOWNSHIP CLERK: _____

22. SIGNATURE OF VOTING CLERK: _____

23. SIGNATURE OF TOWN CLERK: _____

24. SIGNATURE OF TOWNSHIP CLERK: _____

25. SIGNATURE OF VOTING CLERK: _____

26. SIGNATURE OF TOWN CLERK: _____

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97. SIGNATURE OF VOTING CLERK: _____

98. SIGNATURE OF TOWN CLERK: _____

99. SIGNATURE OF TOWNSHIP CLERK: _____

100. SIGNATURE OF VOTING CLERK: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10674
CERTIFICATE OF DEATH

10674
66
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>				c. LENGTH OF STAY IN TB <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 ACCIDENT MD</u>			
				f. STREET ADDRESS <u>1</u>			
				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARVIN</u> Middle <u>GLEN</u> Last <u>CALLIS</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 11, 1907</u>	
				9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NORTHERN HIGH</u>			
11. BIRTHPLACE (State or foreign country) <u>ACCIDENT MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FRANK CALLIS</u>				14. MOTHER'S MAIDEN NAME <u>JANE BOWMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>912-38-5979</u>			
				17. INFORMANT Address <u>Mrs. Lena Callis, Accident, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/17/55</u> , 19____, to <u>10/17/57</u> , 19____, that I last saw the deceased alive on <u>9/24/57</u> , 19____, and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>25 ANDER ST</u> DATE SIGNED <u>10/17/57</u>							
ACTUAL SIGNATURE <u>E. J. Baumgartner</u>				M.D. <u>25 ANDER ST</u>			
PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER</u>				<u>OAKLAND MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 20, 57</u>		<u>BEAR CREEK</u>		<u>ACCIDENT GARRETT CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u>				ADDRESS <u>Quantico Md</u>		24a. RECEIVED BY REGISTRAR <u>Julius K. Rowan RA</u>	
				DATE <u>10/20/57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES EARL RAY		Male		35		White		None	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
Memphis, Tennessee		May 19, 1928		May 14, 1968		10:15 AM		Prison, Nashville, Tennessee	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. NAME OF FUNERAL HOME		15. SIGNATURE OF REGISTRAR	
Felon's escape from prison		Homicide		Nashville, Tennessee		None		[Signature]	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CORONER		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signatures]		[Signature]		[Signature]	

BUREAU V. 5

OCT 29 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10675

CERTIFICATE OF DEATH

106776

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT XI</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARRETT NURSING HOME</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>DEWITT</u> Last <u>DEWITT</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15, 1861</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ACCIDENT MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SOLOMAN BOYER</u>		14. MOTHER'S MAIDEN NAME <u>SALLY MEESE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>WHITFIELD DEWITT, MARY, MD</u>	
17. INFORMANT Address <u>WHITFIELD DEWITT, MARY, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOCLEROTIC CAV DISEASE</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 1</u> 19 <u>56</u> , to <u>OCT. 25</u> 19 <u>57</u> , that I last saw the deceased alive on <u>OCT. 15</u> 19 <u>57</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. I. BAUMGARTNER</u>		ADDRESS (Street, city or town, state) <u>25 ALDER ST</u> DATE SIGNED <u>10/28/57</u>	
PHYSICIAN'S NAME (Type) <u>E. I. BAUMGARTNER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOYES METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>HOYES GARRETT CO, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman, Huntville, MD</u>		24a. REC'D BY REGISTRAR <u>10/27/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. A. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. SEX	
3. RACE		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF REGISTRAR	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE	
15. SIGNATURE OF CORoner		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF OFFICIAL	
19. SIGNATURE OF OFFICIAL		20. SIGNATURE OF OFFICIAL	
21. SIGNATURE OF OFFICIAL		22. SIGNATURE OF OFFICIAL	
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BUREAU V. S.

NOV 12 1957

RECEIVED

11/12/57

10676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park				c. LENGTH OF STAY IN 1b 43 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 1/2 Mi. So. Deer Park, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Deer Park			
f. STREET ADDRESS R. D. Deer Park, Md.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Coy Webster Ervin				4. DATE OF DEATH Month Day Year October 25, 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & Farmer, cutting timber in woods				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Isaac Ervin				14. MOTHER'S MAIDEN NAME Sarah Jane Kitzmiller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give year or dates of service) 220-10-2994		16. SOCIAL SECURITY NO. 220-10-2994		17. INFORMANT Victor Ervin Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial heart disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 64 years 64 yrs 84 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 3, 1955 to Oct. 24, 1957 , that I last saw the deceased alive on Oct. 31, 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED Oct 27 ACTUAL SIGNATURE A. E. Mance M.D. A. E. Mance PHYSICIAN'S NAME (Type) A. E. Mance M.D. Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1957		22c. NAME OF CEMETERY OR CREMATORY Paugh Cemetery		22d. LOCATION (City, town, or county) (State) 2 1/2 Mi. S. Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Mance ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE 10/27/57		24b. REGISTRAR'S SIGNATURE John C. Rowan	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. NO. 100

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF DEATH 10/25/57</p>	
<p>5. PLACE OF DEATH Baltimore, Md.</p>		<p>6. CAUSE OF DEATH Heart Disease</p>	
<p>7. MANNER OF DEATH Natural</p>		<p>8. SIGNATURE OF DECEASED (None)</p>	
<p>9. SIGNATURE OF WITNESSES (None)</p>		<p>10. SIGNATURE OF DECEASED (None)</p>	
<p>11. SIGNATURE OF DECEASED (None)</p>		<p>12. SIGNATURE OF DECEASED (None)</p>	
<p>13. SIGNATURE OF DECEASED (None)</p>		<p>14. SIGNATURE OF DECEASED (None)</p>	
<p>15. SIGNATURE OF DECEASED (None)</p>		<p>16. SIGNATURE OF DECEASED (None)</p>	
<p>17. SIGNATURE OF DECEASED (None)</p>		<p>18. SIGNATURE OF DECEASED (None)</p>	
<p>19. SIGNATURE OF DECEASED (None)</p>		<p>20. SIGNATURE OF DECEASED (None)</p>	
<p>21. SIGNATURE OF DECEASED (None)</p>		<p>22. SIGNATURE OF DECEASED (None)</p>	
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BUREAU V. S.

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G221 10-23-57 et

CERTIFICATE OF DEATH

10677

Reg. Dist. No.

10677/66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AURORA			
c. LENGTH OF STAY IN 1b 1 DAY				d. STREET ADDRESS 85 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First FRONIE Middle AMELIS Last FINT		4. DATE OF DEATH		Month OCTOBER Day 13 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 18, 81		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RED OAK, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN THOMAS CROWE				14. MOTHER'S MAIDEN NAME MARTHA ARONHALT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT "HUSBAND" DANIEL LUTHER FINT, AURORA, W.VA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Hypertensive Cerebro-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH 30 hours 6 years 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1957 to 13 Oct 57 , that I last saw the deceased alive on 12 Oct 57 , 19 57 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 13 Oct 57	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.				OAKLAND,		MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Aurora		22d. LOCATION (City, town, or county) (State) Aurora W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle				ADDRESS Davis, W.V.		24a. REC'D BY REGISTRAR John G. Rowan 24b. REGISTRAR'S SIGNATURE John G. Rowan	

DATE **10/15/57**

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is divided into several horizontal sections with labels for each field.

BUREAU V. S.

OCT 18 1957

RECEIVED

RECEIVED OCT 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10678 CERTIFICATE OF DEATH

10678/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. STREET ADDRESS BOX 163			
3. NAME OF DECEASED (Type or print) First ETHEL Middle MARIE Last GILSON				4. DATE OF DEATH Month OCTOBER Day 17 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY W. GILSON				14. MOTHER'S MAIDEN NAME BROOKS, CINDRELLA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT "SELF"		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171x Uremia & Hydronephrosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix uteri DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 19 to OCT. 17, 1957 , that I last saw the deceased alive on OCT. 17, 1957 , and that death occurred at 12:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.			
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				DATE SIGNED 17 Oct 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 20-57		22c. NAME OF CEMETERY OR CREMATORY Deer Park		22d. LOCATION (City, town, or county) (State) Deer Park Md	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REG'D BY REGISTRAR 10/20/57	
				DATE		24b. REGISTRAR'S SIGNATURE John C. New	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

File No. 10

10-1-57

DATE OF DEATH

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISPOSITION

NAME OF OTHER

NAME OF OTHER

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BUREAU V. 3

OCT 29 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10679

CERTIFICATE OF DEATH

10679

66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN IB 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-KITZMILLER x 2 d. STREET ADDRESS STAR ROUTE - PEERLESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First BIRDIE Middle BLANCHE Last HARVEY		4. DATE OF DEATH Month OCTOBER Day 23 Year 19 57				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES WILSON		14. MOTHER'S MAIDEN NAME MELISSA ELIZABETH WEBB				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARTHA E. WEYANT Address AKRON, OHIO		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RT Lobar (basal) pneumonia DUE TO (c) Arterio sclerosis INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 days 10 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/21/1957 , to 23 Oct 1957 , that I last saw the deceased alive on 23 Oct 1957 , and that death occurred at 4:00 PM , from the causes and on the date stated above.						
ACTUAL SIGNATURE Andrew E Mance		M.D. O A KLAND, MD.		ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 24 Oct 57
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.						
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 10/26/57		22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) Elk Garden, W. Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE O A Sharkless		ADDRESS Blaine, W. Va.		24a. RECEIVED BY REGISTRAR 10/26/57		24b. REGISTRAR'S SIGNATURE Julius A Roman

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. No. 100

PLACE OF DEATH

MARYLAND

DATE OF DEATH

1957

TIME OF DEATH

10:00 AM

PLACE OF DEATH

1000 HILL

DATE OF DEATH

1957

TIME OF DEATH

10:00 AM

PLACE OF DEATH

1000 HILL

DATE OF DEATH

1957

TIME OF DEATH

10:00 AM

PLACE OF DEATH

1000 HILL

DATE OF DEATH

1957

TIME OF DEATH

10:00 AM

PLACE OF DEATH

1000 HILL

DATE OF DEATH

1957

TIME OF DEATH

10:00 AM

BUREAU V. S.

OCT 29 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10680

10680

CERTIFICATE OF DEATH

Reg. Dist. No.

10680/66

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep 01X2-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS Nikep			
3. NAME OF DECEASED (Type or print) First Robert Middle C. Last Kiddy				4. DATE OF DEATH Month October Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1884 72 yrs.		9. AGE (In years lost birthday) 72		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Kiddy				14. MOTHER'S MAIDEN NAME Jane Clayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lottie Kiddy		Address Nikep, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mo							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 30 , 19 57 , to October 4 , 19 57 that I last saw the deceased alive on Sept 1 , 19 57 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 10/6/57							
ACTUAL SIGNATURE E. L. Baumgartner M.D. 25							
PHYSICIAN'S NAME (Type) E. L. BAUMGARTNER Oakland Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/57		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR 10/7/57	
				24b. REGISTRAR'S SIGNATURE John M. Brown		24c. REGISTRAR'S SIGNATURE RR	

CERTIFICATE OF DEATH

NAME OF DECEASED George Richmond		SEX Male		AGE 35	
DATE OF BIRTH October 12, 1921		PLACE OF BIRTH London, England		OCCUPATION Police Officer	
DATE OF DEATH November 12, 1957		PLACE OF DEATH London, England		CAUSE OF DEATH Heart Disease	
TIME OF DEATH 10:15 AM		PLACE OF DEATH London, England		MANNER OF DEATH Natural	
NAME OF NEXT OF KIN James Clayton		ADDRESS 10, Whitehall, London, S.W. 1		SIGNATURE OF NEXT OF KIN James Clayton	
NAME OF REGISTRAR Robert Hodge		ADDRESS 10, Whitehall, London, S.W. 1		SIGNATURE OF REGISTRAR Robert Hodge	
NAME OF MEDICAL OFFICER James Clayton		ADDRESS 10, Whitehall, London, S.W. 1		SIGNATURE OF MEDICAL OFFICER James Clayton	
NAME OF BURIAL OFFICER James Clayton		ADDRESS 10, Whitehall, London, S.W. 1		SIGNATURE OF BURIAL OFFICER James Clayton	

BUREAU V. 2

OCT 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10681

CERTIFICATE OF DEATH

Reg. Dist. No.

10681

166

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	c. LENGTH OF STAY IN 1b 35 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Oakland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4th St.		d. STREET ADDRESS 4th St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Donna Middle Hanna Last Littman		4. DATE OF DEATH Month October Day 28, Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1899
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife & retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Hanna		14. MOTHER'S MAIDEN NAME Ella Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Julius B. Littman		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis & Diphtheria 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic muscular atrophy DUE TO (c) 4 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 19 54 , to Oct 28, 19 57 , that I last saw the deceased alive on Oct 28, 19 57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 10/30/57			
ACTUAL SIGNATURE E. I. Baumgartner M.D.		DATE SIGNED 10/30/57	
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/1957	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE Julius B. Littman	



BUREAU V. S.

NOV 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10682

Reg. Dist. No. 766

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle RAY Last MC COMBIE				4. DATE OF DEATH Month OCTOBER Day 10 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-58		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shreveport, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT LAWRENCE MC COMBIE				14. MOTHER'S MAIDEN NAME GLADYS MAE SHIPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT " GLADYS M MC COMBIE (MOTHER) FRIENDSVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Typhoid Fever DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. Baumgartner M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) E. I. BAUMGARTNER, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Steel Cemetery		22d. LOCATION (City, town, or county) (State) near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR 10/13/57 DATE		24b. REGISTRAR'S SIGNATURE John C. K...	

12/07/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10683

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) THOMAS First MC ROBIE Last				4. DATE OF DEATH OCTOBER Month 1 Day 1957 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/72	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANCIS MC ROBIE				14. MOTHER'S MAIDEN NAME LUCY MC ROBIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MRS JAMES SHAFFER Address SWANTON MD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Arterio-sclerotic renal vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia bilateral (c) 8 years INTERVAL BETWEEN ONSET AND DEATH 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/24/1957 to 10/1/1957 , that I last saw the deceased alive on 10/1/1957 , and that death occurred at 12:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 10/5/57			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-3-1957		22c. NAME OF CEMETERY OR CREMATORY MC ROBIE CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR SWANTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldwin ADDRESS OAKLAND MD				24a. REC'D BY REGISTRAR DATE 10/3/57		24b. REGISTRAR'S SIGNATURE John H. Brown	

MARIANO STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10684

CERTIFICATE OF DEATH

10684/6
Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 WEEKS NURSING HOME		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First JOHN Middle NELSON Last MICHAEL		4. DATE OF DEATH Month OCT. Day - 1 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB-9, 1879
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CONRAD MICHAEL		14. MOTHER'S MAIDEN NAME AMANDA SAUAGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 26-07-6061	
17. INFORMANT ARTHUR MICHAEL		Address 1850 LANCASHIRE DETROIT MICH.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9049 (b) ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture RT. femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT , 19 57 to OCT , 19 57 , that I last saw the deceased alive on SEPT 30 , 19 57 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ALDER ST OAKLAND MD DATE SIGNED 10/1/57 ACTUAL SIGNATURE E. J. Baumgartner PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-3-1957	
22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		24a. REC'D BY REGISTRAR 10/3/57 24b. REGISTRAR'S SIGNATURE John G. Hough	

CERTIFICATE OF DEATH

NAME OF DECEASED: *WILLIAM J. HARRIS*
AGE: *74*
SEX: *M*
DATE OF DEATH: *10-1-57*
PLACE OF DEATH: *HOME*
CAUSE OF DEATH: *HEART DISEASE*
MANNER OF DEATH: *NATURAL*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF REGISTRAR: *[Signature]*

REAU V. S.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10685

CERTIFICATE OF DEATH

10685/66
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. No. Swanton				d. STREET ADDRESS 4 Mi. No. Swanton			
3. NAME OF DECEASED (Type or print) First Stella Middle Florence Last Paugh				4. DATE OF DEATH Month October Day 2 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Howell				14. MOTHER'S MAIDEN NAME Delilah Wilt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Stewart Paugh Address Swanton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular Fibrillation & Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio. Renal Disease DUE TO (c) Obesity						INTERVAL BETWEEN ONSET AND DEATH 3 mos 7 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-23-57 to 9-30-57 , that I last saw the deceased alive on 9-30-57 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster Jr.				ADDRESS (Street, city or town, state) 58 2nd St Oakland - Md DATE SIGNED 10-4-57			
PHYSICIAN'S NAME (Type) James H. Feaster Jr.				OAKLAND, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY North Glade Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.		24a. RECEIVED BY REGISTRAR DATE 10/5/57	
				24b. REGISTRAR'S SIGNATURE Julius C. Rowan			

OCT 9 1957

RECEIVED

10686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORINTH 85 x - 3			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle WALTER Last PHILLIPS				4. DATE OF DEATH Month OCTOBER Day 12 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/81	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROADER				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JACOB PHILLIPS				14. MOTHER'S MAIDEN NAME UNKNOWN Ella Poling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO				16. SOCIAL SECURITY NO. 234-12-0565		17. INFORMANT Address DAUGHTER (MRS. PEARL FREELAND)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Atelectasis, Pneumonitis, right lung 6 days DUE TO Cerebral Vascular Accident 2 mos. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease 10 years DUE TO (c) Arteriosclerotic Cardiovascular Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/8 , 19 57 , to 10/12 , 19 57 , that I last saw the deceased alive on 10/12 , 19 57 , and that death occurred at 1:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 OAK STREET DATE SIGNED OCTOBER 12, 1957							
ACTUAL SIGNATURE Herbert H. Leighton M.D.							
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal to Burial		12/14/57		Knight of Pythias Cemetery Newburg, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Phillips				ADDRESS Terra Alta		24a. REC'D BY REGISTRAR DATE 12/14/57	
						24b. REGISTRAR'S SIGNATURE Judith Rowan	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. BURKAY		MALE		45		JAN 15 1912		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
OCT 17 1957		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES OF AMERICA		OCT 17 1957		BALTIMORE		MARYLAND	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF CORONER		NAME OF MINISTER		NAME OF BURIAL		NAME OF FUNERAL HOME		NAME OF CEMETERY	
JAMES H. BURKAY		BALTIMORE HOSPITAL		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF CORONER		SIGNATURE OF MINISTER		SIGNATURE OF BURIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	
JAMES H. BURKAY		BALTIMORE HOSPITAL		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY		JAMES H. BURKAY	

BURKAY J. S.

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10687 66

CERTIFICATE OF DEATH

Reg. Dist. No.

10687

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle L. Last SISK				4. DATE OF DEATH Month OCTOBER Day 11 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/22/75	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engin Tender for Balto. & Ohio R R Co		11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY, SISK		14. MOTHER'S MAIDEN NAME DELLA SPENCER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-12-3280		17. INFORMANT Address Mrs. D. E. Callis Mt. Lake Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days 15-20 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/9/ 19 57 , to 10/11/ 19 57 , that I last saw the deceased alive on 10/11/ 19 57 , and that death occurred at 10:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED Oct 11, 1957			
PHYSICIAN'S NAME (Type) HERBERT LEIGHTON M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/1957		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 10/14/57	
24b. REGISTRAR'S SIGNATURE Julius A. Rowan				LR			

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10688 CERTIFICATE OF DEATH

Reg. Dist. No.

10688/66

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 RURAL SWANTON d. STREET ADDRESS ROUTE #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Brenda Kay TICHINEL Middle Last BABY GIRL				4. DATE OF DEATH OCTOBER 1 19 57 Month Day Year			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 29, 1957	
9. AGE (In years lost birthday) yrs. 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME TICHINEL, JAMES				14. MOTHER'S MAIDEN NAME BOYCE, JUANITA VIRGINIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Tichinel, R#1, Swanton, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 MULTIPLE Congenital Anomalies DUE TO Bilateral Harelip, cleft Palate, Imperforate Anus and Polydactylism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Polycystic (c) Polycystic						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19. 10/1				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/29 , 19 57 , to 10/1 , 19 57 , that I last saw the deceased alive on 10/1 , 19 57 , and that death occurred at 12:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) R#1, Swanton, Md. DATE SIGNED 10-2-57							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D. 38 2nd St. Oakland Md 10-2-57				PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M. D. OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2/57		22c. NAME OF CEMETERY OR CREMATORY Turner Cemetery		22d. LOCATION (City, town, or county) (State) R#1, Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE O. H. Sharpleas ADDRESS Blaine, W. Va.				24a. REC'D BY REGISTRAR 10/2/57		24b. REGISTRAR'S SIGNATURE Julius A. Rowan	

2070378XV4

BUREAU V. S.

OCT 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10689

CERTIFICATE OF DEATH

Reg. Dist. No.

10689
166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SWANTON x/	
d. STREET ADDRESS ROUTE # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KATHLEEN LENORE TICHNELL		4. DATE OF DEATH Month Day Year OCTOBER 28 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK JUNKINS		14. MOTHER'S MAIDEN NAME MAUDE GRIFFITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT ARTHUR TICHNELL - ROUTE # 1 - SWANTON, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebruma of Liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 9, 1957</u> , to <u>OCTOBER 27, 1957</u> , that I last saw the deceased alive on <u>October 27, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.		ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>29 Oct 57</u>	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Oct. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Tichnell Cem.	22d. LOCATION (City, town, or county) (State) GARRETT Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Rood</u> ADDRESS WESTERNPORT, MD		24a. RECEIVED BY REGISTRAR DATE 10/31/57	
24b. REGISTRAR'S SIGNATURE <u>John P. Rowan R.P.</u>			

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1990



RECEIVED
10/31/21

NOV 12 1957

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10690

Reg. Dist. No. 172

10690

1. PLACE OF DEATH COUNTY GARRETT MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER HOSPITAL OR INSTITUTION OR STREET ADDRESS E. MAIN STREET				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY GARRETT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER STREET ADDRESS (If rural give location) E. MAIN STREET			
3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) DANIEL (Last) WALKER				4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 22, 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 23, 1861	9. AGE last birthday 96 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner		11. BIRTHPLACE (State or foreign country) Union Co., Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONATHAN CLARK WALKER				14. MOTHER'S MAIDEN NAME ALICE PENLAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO		16. SOCIAL SECURITY NO. 232-26-0520-A		17. INFORMANT & ADDRESS J.W. WALKER, SHALLMAR, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Acute Pulmonary Edema ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Bilateral Segmental Hemiparesis				INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs 10 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1947 , to Oct. 22, 1957 , that I last saw the deceased alive on Oct. 22, 1957 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
SIGNATURE Malph Colandrella		M.D. Kitzmillr Md		DATE SIGNED Oct. 22-57			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct. 25/57		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, W.Va.	
24. REC'D BY REGISTRAR 10/24/57		REGISTRAR'S SIGNATURE AW Barrick		25. FUNERAL DIRECTOR'S SIGNATURE O H Shorless ADDRESS Blaine, W.Va			

CERTIFICATE OF DEATH

Reg. Off. No.

1. MEDICAL RESIDENCE NUMBER OF DECEASED

2. NAME OF DECEASED

3. SEX

4. AGE

5. RACE

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. SEX

13. RACE

14. AGE

15. NAME OF DECEASED

16. NAME OF DECEASED

17. NAME OF DECEASED

18. NAME OF DECEASED

19. NAME OF DECEASED

20. NAME OF DECEASED

21. NAME OF DECEASED

22. NAME OF DECEASED

23. NAME OF DECEASED

24. NAME OF DECEASED

25. NAME OF DECEASED

26. NAME OF DECEASED

BUREAU V. 3

OCT 28 1957

RECEIVED

INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10691

CERTIFICATE OF DEATH

Reg. Dist. No.

1069166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) F. Street		d. STREET ADDRESS F. Street	
3. NAME OF DECEASED (Type or print) First Laura Middle G. Last Welch		4. DATE OF DEATH Month October Day 18 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Md. Public school	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Weimer		14. MOTHER'S MAIDEN NAME Nancy Jane McRobie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Joseph H. Welch		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myasthenia Gravis 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 57 , to Oct 18 , 19 57 , that I last saw the deceased alive on Oct 18 , 19 57 , and that death occurred at 7:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md.	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		DATE SIGNED Oct 20, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/21/1957	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR 10/21/57
			24b. REGISTRAR'S SIGNATURE Robert P. Brown

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10692

Items 11, 12 fill mg221 10-14-57 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10692/66

1. PLACE OF DEATH a. COUNTY GARRETT Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPRETS NURSING HOME		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) ELLAZAN ELIZABETH WINTERS		4. DATE OF DEATH OCT. 6 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-13-1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Oakland(rural), Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB HAUSER		14. MOTHER'S MAIDEN NAME MARGARET ROTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CARL WINTERS Address OAKLAND MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypochromic Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1956 , to Oct 1957 , that I last saw the deceased alive on October 4, 1957 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. I. Baumgartner M.D.		DATE SIGNED 10/7/57	
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER		ADDRESS (Street, city or town, state) 2500 1st St Oakland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-9-1957	
22c. NAME OF CEMETERY OR CREMATORY RED HOUSE CEMETERY		22d. LOCATION (City, town, or county) (State) RED HOUSE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR DATE 10/8/57	
24b. REGISTRAR'S SIGNATURE John Brown			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

RECEIVED
OCT 9 1957
BUREAU V. S.

Handwritten signature and date at the bottom of the page.